IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF MISSISSIPPI
EASTERN DIVISION

JEANETTER GRAHAM, INDIVIDUALLY AND
AS WRONGFUL DEATH BENEFICIARY OF
ALBERT GRAHAM, DECEASED PLAINTIFF

VS. CAUSE NO. 2:13cv67-KS-MTP

ALEX HODGE, INDIVIDUALLY AND IN HIS
OFFICIAL CAPACITY AS SHERIFF OF JONES
COUNTY; JONES COUNTY, MISSISSIPPI AND
DEPUTY "JOHN DOE" IN HIS OFFICIAL CAPACITY
DEFENDANTS

DEPOSITION OF MALCOLM TAYLOR, M.D.,

Taken at the instance of the Plaintiff at Jackson Cardiology Associates, 971 Lakeland Drive, Ste. 850, Jackson, Mississippi, on Monday, July 28, 2014, beginning at approximately 2:30 p.m.



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EXHIBITS





STIPULATION

It is hereby stipulated and agreed by and between the parties hereto, through their respective attorneys of record, that this deposition may be taken at the time and place hereinbefore set forth, by Tamika Bartee, Court Reporter and Notary Public, pursuant to the Rules;

That the formality of reading and signing is specifically NOT WAIVED;

That all objections, except as to the form of the questions and the responsiveness of the answers, are reserved until such time as the deposition, or any part thereof, may be used or sought to be used in evidence.

* * *





EXHIBIT 17

MALCOLM TAYLOR, M.D.,
Having been duly sworn and examined, testified as follows:
EXAMINATION BY MR. SANDERS:
Q. Would you state your name, please?
A. Malcolm P. Taylor.
Q. Dr. Taylor, I take it that you have given depositions previously?
A. Yes, sir.
Q. And if I should ask you a question you don't understand, please ask me to repeat it, otherwise I am going to assume that you answered the question that I asked. Fair enough?
A. Correct.
Q. Thank you.
MR. DARE: Can we have the same stipulations?
MR. SANDERS: Yes.
MR. DARE: All of my objections, except to the form of the question, are reserved until trial or at hearing or until such time as I can raise that.
MR. SANDERS: That's fine.
MR. DARE: Thank you.
BY MR. SANDERS:



Q. Would you give us a little of your educational background, Dr. Taylor?
A. Well, I am from Vicksburg, Mississippi. I went to college at Tougaloo College here in Jackson, and then on to Tufts University in Boston, Massachusetts where I received my M.D. degree.
And I did my internal medicine training at the Washington Hospital Center and then my cardiology fellowship at Georgetown University in Washington DC. And that was completed in 1978.
Q. Good. Do you practice in the area of cardiology?
A. Yes.
Q. And where are you employed?
A. For Jackson Cardiology Associates here in Jackson, Mississippi. I started this practice along with Dr. T. B. Ellis in 1978.
Q. Did you have an occasion to review certain documents in connection with Albert Graham, the late Albert Graham?
A. Yes. I had an opportunity to review his medical records from South Central Regional Medical Center, and also some records where he visited one of the cardiologist down in, I think it was Hattiesburg. And also an incident report from the



Jones County Detention Center.
And I also had a chance to review the coroner's report and medication list from Walmart, as well as the records from Jefferson Medical Associates.
And I also reviewed the complaint and some of the interrogatory answers and the questions, as well as the depositions of Ms. Graham, Jerald Ulmer and Terryl Ulmer.
Q. Did you do a report in connection with --
A. Yes. I did a report back in April of this year and submitted it to Attorney Dare.
Q. Have you reviewed any additional documents since then?
A. I have reviewed -- there was a deposition from the cardiologist that I had a chance to peruse; not in detail, but I did read some of his statements.
And I have a deposition of the nurse who saw him, but I have not read it.
Q. You did read the deposition of Ms. Graham, you said?
A. Yes, right.
Q. Now, based upon your reading of the documents, you prepared a report. Is that correct?



A. That's correct.
Q. Now, you indicated that Mr. Graham did not have myocardial infarction, what is that?
A. That is damage from poor circulation. Well, it depends on -- let me define that two ways:
A myocardial infarction is an acute occlusion of an artery to the heart that leads to a lack of blood flow to the heart causing damage. That's a myocardial infarction.
Q. And you concluded that -- that his death was not associated with that, with a heart attack?
A. Right, right. I felt he died of what we call a sudden cardiac death. And in a patient with known heart disease, with a prior history of heart disease, the most common cause is arrythmia, abnormal beating of the heart, and it's associated with poor outcomes outside the hospital setting.
Q. Did Mr. Graham have a history of cardiac arrythmia?
A. He had had, I think, an arrythmia treated in Laurel when he had a stroke. I think he had a history of congestive heart failure, and he came in the second time with a stroke, which was felt most likely to be related to a cardiac arrythmia such as atrial fibrillation. Although that was not

documented, he was placed on a blood thinner.
Q. Okay. So cardiac arrythmia is abnormal beating of the heart?
A. Right. Correct.
Q. Can that be treated?
A. Yes. If it's in a -- if it's acute, it has to be treated in a hospital setting, and that's why there is such a high mortality when patients are not in the hospital when they have a malignant cardiac arrythmia.
There are other arrythmias of the heart that are not life-threatening, but still can be quite devastating, but not life-threatening at the time they occur that can be treated as an outpatient or either in a hospital setting, but it doesn't cause total cardiac collapse. And that's what happened to him.
Q. Can it be treated with medication?
A. The arrythmias are normally treated with medication. And also, you oftentimes treat the underlying cause of the arrythmia, which could be damage to the heart from high blood pressure; damage to the heart from illicit drug use, such as cocaine, alcohol, or some people end up with viral damage to the heart. All of those things that you can treat



may make the arrythmia go away because the heart gets better.
Q. What kind of medications would --
A. Well, for our arrythmias, we use a lot of different medications. It depends on whether it is chronic or acute. The most -- acutely with an arrythmia for a cardiomyopathy type patient would be a drug called amiodarone or Pacerone.
We can use beta blockers, digitalis. We can use -- there are a number of other drugs, Betapace. There are a lot of different drugs that we can use to suppress arrythmias.
Some drugs suppress abnormal rhythms in the top part of the heart better and some suppress abnormal rhythms in the bottom part of the heart, meaning the ventricle, better.
Q. Beta blockers are used --
A. Uh-huh (affirmative response).
Q. Do you know from your examination of the pharmacy records of Mr. Graham whether or not he was on beta blockers?
A. Yes. He had taken a beta blocker called coreg in a very low dose.
Q. And what does coreg do?
A. Coreg is a beta blocker. It has multiple



uses: One is congestive heart failure. Two is hypertension. Three is heart attacks. Four is control of heart rate in abnormal rhythms like atrial fibrillation.
So multiple indications for coreg depending on the type of illness the patient experiences.
Q. In terms of Mr. Graham, were you able to determine why --
A. Why he was on it?
Q. Yes.
A. He was on coreg, according to the cardiologist, because he had congestive heart failure. He started on low dose coreg, which decreases -- which helps improve heart function. It decreases the amount of oxygen the heart needs to perform a certain amount of work. It slows the heart rate down and it lowers blood pressure, although the dosage he was on were not for blood pressure.
Q. You determined that his death was related to cardiac arrythmia caused by ventricular tachycardia.
Is that correct?
A. Correct. Ventricular tachycardia and



fibrillation.
Q. Okay. Ventricular tachycardia, what is that?
A. It's an abnormal beat of the bottom part of the heart, which would be the ventricle of the heart. It's more life-threatening associated with low blood pressure, absence of blood pressure, absence of pulse. And it deteriorates overtime into ventricular fibrillation, which is arrythmia where the heart is not pumping at all, it is just quivering.
Q. Would it be fair to say that coreg is used to treat ventricular tachycardia?
A. No, it would not be used to treat ventricular tachycardia.
Q. Well, what medication would you use?
A. Well, ventricular tachycardia, the first thing you're going to do is shock the patient electrically to convert them. We use drugs like amiodarone in the acute setting with a cardiac arrythmia.
We use cardiac defibrillators. Those are going to be the main drugs to use for ventricular tachycardia.
Then some patients may even get what we

call an ablation, which is using a laser to actually burn the part of the heart that's causing this excitable rhythm. That's one other way to treat it.

But beta blockers are not used to treat ventricular tachycardia or ventricular fibrillation, although they may help it in the long run to prevent it, but once you have it, you have it.

Q. But the beta blockers slow down the beat of the heart, right?

A. Yeah. The normal beating of the heart, not the -- and it will slow down ventricular tachycardia; it will slow down the normal beating of the heart, and it would slow atrial fibrillation, which is a another type of abnormal beat of the heart. Probably about 4, 5 million people in this country have that rhythm. He did not have that documented, atrial fibrillation.

Q. Were you able to determine -- well, you determined that Mr. Graham's failure to receive medication during the time that he was incarcerated did not cause his death.

Is that correct?

A. Yeah. That's correct. I think he had a severe cardiomyopathy, and if you can go back and look at his records, he was on multiple drugs back



in 2008, 2009, but apparently had discontinued many of these drugs on his own and had not followed up with a cardiologist. So he was on suboptimal therapy for his cardiac problem. Mainly because he didn't get the drugs.

Q. You said that he had discontinued the drugs?

A. Yes.

(Exhibit 1 marked.)

BY MR. SANDERS:

Q. In reviewing -- well, let me hand you this and ask you if you've seen this.

A. Yes. This is a medication list from 2007, 2008. And there is one prescription for 2009.

Q. Okay. That was the coreg?

A. Right.

Q. So you had indicated that he had stopped taking the medications?

A. Well, there is no evidence he was getting it from the pharmacy; so, you know, we normally follow your prescription records or the records from the doctor.

And after 2009, there was only one prescription in 2000 -- after 2008, there was only one prescription in June of 2009, and that was for



Carvedilol. All the other medication that he had previously been on in 2008, there was no evidence that he was getting that by his pharmacy.

Q. Okay. Are you aware that Ms. Graham testified that during a period of time that he was receiving samples that were being supplied by the drug companies or the detailers?

A. Well, I read that; but, I just know in my own experience, some of these drugs are not -- these drugs are not supplied by drug companies on a regular basis, other than maybe the Diovan, and usually not in the dose that he was on; he was on 40. Most times they're going to supply that drug, it's in 80.

Digitalis would never be supplied as a drug; it's too old. Lasix, which is a fluid pill, would not be supplied; they don't sample that. And coreg, Carvedilol, they would not sample the dose that he was on during that time. I think they had gone to maybe some other type of formulation.

So of the drugs he was getting here, I don't see how she could have gotten samples on a regular basis because most of the time they don't sample these.

Q. Did you read Dr. Mouannes' deposition



where he says that they did provide samples of the medication that he was taking?

MR. DARE: Object to the form of the question.

THE WITNESS: I don't remember that. Which one did he provide because -- I just don't see -- in my experience as a cardiologist, we just don't get these drugs. Especially digitalis, Lasix, they're generic, so...

But also, I would think that also we would not -- if you're supplying samples, you know, he would have needed samples for almost a year and a half or so.

BY MR. SANDERS:

Q. Okay. The last prescription that you see is in June, right?

A. Yes, June 2009. That was just a 30-day supply, I believe.

Q. So that would get him to July?

A. Right.

Q. Now, I notice that you indicated that the failure to provide him with medication between November and April, or November and March -- I'm sorry -- November of 2009 and March of 2010 did not cause his death and you went on to qualify that.

I think you said that because he suffered death related to cardiac arrythmia that he had not been on the appropriate medication for at least a year and that he did not have an internal cardiac defibrillator.

Is that correct?

A. Right.

Q. Now, would it be fair to say that the absence of the medication contributed to his death?

A. Well, my feeling is he was on inadequate -- if you're talking about one drug, coreg, he was on a very small dose. The treatment of congestive heart failure is a combination of drugs that he was on originally.

And so the fact that he, at this point, appears to be only on one drug that he had back in June, had not -- or at least had no evidence that he got for four months or before his incarceration -- anything is possible. I don't think it is probable to a reasonable degree of medical certainty that that would have played a role in his death had he gotten it.

Q. Well, what I am trying to understand is, you said he had not been on proper medication for at least a year?



A. Right.

Q. So I assume that -- well, what did you mean when you said "proper medication"?

A. Well, proper medication. Well, you know, he was on digitalis, Carvedilol, Lasix and Diovan as a combination of drugs for treatment of his heart failure.

Q. Okay.

A. And that is the acceptable medical treatment for a patient with his medical -- with his heart problem. It's just that there is no evidence that he got any of those drugs except Carvedilol in June of 2009 from when he called in the prescription for him.

So he had periods where he was off of medication for long periods of time, and then when I look at the dose of Carvedilol he was on, it was a very, very small dose. So I don't think that would have made a difference in his survival long-term.

Q. Well -- I'm sorry.

A. Mainly because his heart problem was associated with a 50 percent mortality in five years.

Q. Well, what I am trying to determine is, if he did not have the medications that he needed



for a year prior to his death, is that what we're talking about?

A. Right.

Q. And of that time that he did not have that medication, he was incarcerated?

MR. DARE: Object to the form.

THE WITNESS: Well, it looks to me like 2008 was the last time he had medication that was inclusive of all the things he was getting.

It appeared that in some kind of a way in 2007 he was on adequate therapy. In 2008, some of that therapy changed and dropped out. I don't see lisinopril. I don't see -- on this medication list, I don't see Diovan except in 2009, January. It looks like that was the last time he got that.

So it would have been a year since he had any Diovan, maybe even more than that for the Lanoxin or digoxin. And we know he got a prescription for Carvedilol in June of 2009.

So there appears to be a sporadic use of medication; for the majority periods of time he appeared to be off medication for whatever reason, or there was no evidence that he was taking medication. And he saw no provider, which is unusual in a patient with this degree of heart



disease.

BY MR. SANDERS:

Q. At the time when Mr. Graham was incarcerated, had he been taken to a cardiologist at that point in time, could the cardiologist have taken the appropriate steps to preserve his life?

A. Well, yes, if he had been taken to a cardiologist when he came in. If he would have setup an appointment with the cardiologist, he would have had an echo of his heart. And he had not had an echo, so we really don't know the status of his heart from the time he was last seen by the cardiologist in Laurel until he died because he didn't go back for follow up. He didn't get a followup echo. He had a stress test that was abnormal, but he didn't follow up.

So if you say, okay, Mr. Graham, we're going to send you to a cardiologist, the cardiologist would have had to do an echo. And then when he saw the echo, he would have treated the changes. If the heart function was still poor, which I think it probably was, he would have started him on the same drug that the original cardiologist had him on, all four of those drugs, or at least three of those drugs: Carvedilol, either lisinopril

or Diovan. Maybe even Lanoxin as a fourth drug. And Lasix, which is a fluid pill as needed. But he did not see a cardiologist when he was in prison.

Q. He did see a medical person in March of 2010. Is that right?

A. Yes. He went to see a nurse practitioner. I forgot her name. It is in my report. He had high blood pressure, and that was at the Ellisville Medical Clinic. His blood pressure was elevated and the nurse practitioner who saw him noted that he had not taken any medication in over a year and started him on Lotensin/HCT, which is a blood pressure pill.

Q. Assuming that the nurse was aware of the fact that he had a history of heart problems, was it reasonable for her to send him to a nurse practitioner versus a heart specialist?

MR. DARE: Object to the form of the question.

You can answer.

THE WITNESS: Well, I think the key reason she was sending him for treatment was for blood pressure, so she was sending him to someone who could treat that.

And then it would be incumbent upon the



nurse practitioner to get a history and decide if they need to send him for other tests or to a specialist.

So I think the nurse did the right thing. He complained of some problems, so she said, 'Okay. I will get his nurse practitioner.' The nurse practitioner said he had high blood pressure, and that examination, there was no evidence that he was to be compensated so they treated his blood pressure, which is appropriate. And that drug is a good drug and not inappropriate. It actually does help the heart a little bit as well, but he was treating high blood pressure.

BY MR. SANDERS:

Q. I'll hand you this document and ask you if you've seen that.

A. Yes. I've seen this document before from Jones County Detention Center.

Q. In that document he indicates that he had what medical problems?

A. Well, on here it says, "Congestive heart failure; says it's borderline." And then "corad" I'm sure that means coreg. "Heart condition and disability." That's what I see under "explanation of questions." I am not sure who typed that in for



him.

Q. There is no indication that he has any high blood pressure, is there?

A. No. It is kind of -- yeah. There is no indication. Although high blood pressure is a medical question on the sheet at the top, in the middle, next to -- between epilepsy and ulcers is high blood pressure. So I don't know what he answered to that.

Q. Yeah, he answered "yes."

A. Okay.

Q. Can you say that the failure to have an internal cardiac defibrillator contributed to Mr. Graham's death?

A. Well, yes. More likely than not the lack of a defibrillator meant that he --

Let me put it like this. More likely than not, the presence of a cardiac defibrillator would have saved his life.

Q. So the lack of one?

A. The lack of one contributed to his not surviving his cardiac arrest.

Q. Now, the lack of medication contributed to his death. Is that correct?

A. Well, the lack of adequate optimum



therapy contributed to his ultimate cardiac demise.

Q. Okay. Tell me what that means.

A. The lack of optimal therapy, optimal meaning, the drugs that his cardiologists had put him on, which was a combination of drugs, ACE inhibitors, beta blocker, fluid pill and digoxin. A lack of that combination of drugs, contributed to his cardiac demise.

Q. And you can say that to a reasonable degree of medical certainty?

A. Well, yeah. I think the fact that he didn't have any medication that was optimal for his heart condition would be a problem. But he had been without that medication long before he was incarcerated to the point that it appeared he didn't think that was a part of his regular regiment.

Q. Can you say that the deprivation of the medication during the time that he was incarcerated had nothing to do with his demise?

A. Well, the only medication that he told them about was coreg. And he was on a very low dose, and had not, at least, for sure, not taken it since July of that year.

I don't think the presence of that one drug with a patient with his degree of heart disease

would have changed his outcome. Anything is possible, but the probability to a degree of medical certainty, I don't think would have played a role -- the presence of coreg alone would have changed his outcome and not cause him to have a cardiac arrest.

Q. Well, I'm not only focussing on coreg. I am focusing on -- well, your review of the medical records indicated that he didn't receive any kind of medication from the time he was incarcerated until March of 2010. Is that correct?

A. Right.

Q. And what I am saying is, during that period of time, the deprivation of that medication, did it -- the entire medication, did that contribute to his death?

A. Well, yeah. When the entire regiment he had been on -- so he had a worsening of his heart condition because he was not on an entire regiment that he had been on in 2007. But that regiment had changed before he was incarcerated.

But I was trying to say that just to say coreg would have made the difference in his survival as opposed to all the other drugs he should have been on, to a reasonable degree of medical certainty, I don't think that that was correct.



Q. But what I am asking is, the deprivation of those, the entire panoply -- well, maybe that's not --

A. Concoction or the right combination?

Q. Right. Well, for the period of his incarceration, can you say that that contributed to his --

A. Well, and there was no reason to think his heart was going to get better. So I would say the lack of medication for a heart condition allowed it to deteriorate.

Q. Okay. And that's to a reasonable degree of medical certainty?

A. Yes.

Q. Based upon your review of the medical records -- well -- strike that.

Is it your understanding that based upon your review of the medical records that whether drugs were available to Mr. Graham was not totally dependent upon -- totally dependent upon him?

A. Well, the availability of the drugs, you mean, while he was incarcerated?

Q. Right.

A. Because the availability of drugs prior to incarceration was totally up to him.



Q. Correct.

A. After he was incarcerated, the only drug he mentioned to them was coreg, and he did not get coreg while he was incarcerated.

But coreg alone, I don't think was enough to make a difference in his survival.

Q. That's based on the records, you say the only thing he mentioned. That was based on your review of the records?

A. Right. I am just looking at what the record says.

Q. Were you aware that he had requested to get medication during the time that he was incarcerated?

A. No, I don't remember that. I remember he fell sick; he went to the nurse and she immediately sent him over to see the nurse practitioner, and he did get medication because his blood pressure was high.

Q. Would it be fair to say that your determination as to the time period that he was without medication prior to his incarceration is based upon Exhibit 1, the medication from Walmart?

A. Yes.

Q. Now, what was the drug you said that was



prescribed by the --

A. Lotensin/HCT.

Q. Okay. And what is that?

A. That's a high blood pressure medicine. It's an ACE inhibitor, plus a small dose diuretic, frequently used for hypertension. It's indicated for hypertension.

Q. You indicated that it would have been left up to the nurse practitioner to determine based upon a history what other ailments Mr. Graham had. Is that correct?

A. Yes. Once the nurse practitioner is evaluating the patient and getting a history, then it would be up to that person to the best of their medical ability to decide what's the next step. And the reason he had come, he thought his blood pressure was up. And as it turns out it was, and his nurse practitioner gave him medication that was more than adequate to treat that.

Q. Assuming that the nurse was aware of Mr. Graham's prior heart condition, and that he had not had medication for a substantial period of time included in his incarceration, to determine the appropriate treatment, wouldn't it have been more appropriate to send him to a hospital emergency

room?
MR. DARE: Object to the form of the question.
THE WITNESS: Well, it just appears from the note that was written that he was not acutely ill. My interpretation of the note from the nurse practitioner, it wasn't like he had rapid pulse or he was short of breath in heart failure, grossly. He had high blood pressure and was treated.
So just based on that note, it didn't seem like he needed to go to the emergency room. You would start him on the blood pressure medication and then perhaps follow him up in a month or so or a week or so, depending on whatever they do in prison in terms of getting patients followed up.
BY MR. SANDERS:
Q. Were you aware that the nurse had reviewed his -- the same medical records that you had?
A. Well, the nurse -- which nurse? Are we talking about the nurse in prison or the nurse practitioner?
Q. The nurse in the prison.
A. Okay. The nurse in the prison had access to, I guess, all these medical records. I assume



this intake sheet would be available in his records. And she sent him over to the nurse practitioner, which was appropriate for therapy. I have not read her deposition as to how many times she may have looked at his records or whatever. How many times she had seen him.
Q. What I am saying is, you were not aware that the nurse at the prison had reviewed his medical records the same one that you reviewed prior to her sending him to the nurse practitioner?
A. No, no. I don't remember a statement to that effect. She may have said that in her deposition, which I have not read.
Q. Yeah, she did.
Wouldn't the nurse have been in a position to make a determination that based upon those records that he needed to have cardiac treatment?
A. Well, I think, based on what his complaints were, she was going to send him over for an examination by a well-trained professional, a nurse practitioner, which was one level above her for an evaluation, and then leaving it to the nurse practitioner to decide what the next step was.
And the nurse practitioner decided to



treat him and did not refer him out. It didn't seem like he needed to go to the emergency room. You know, his cardiac arrest wasn't until the next month.
Q. So if he had had a cardiac arrest then --
A. Well, it was just that things change overtime. He was seen in March and treated for high blood pressure and apparently did not have to go back to see the doctor. There is no records of any medical treatment or complaints, that I saw, and he died suddenly in his cell in April of 2010, essentially a month later or three weeks later or so.
So I was just saying it didn't appear that he was acutely ill when the nurse practitioner saw him, based on the nurse practitioner's note that he needed to go from the nurse practitioner to the emergency room.
Q. It would be fair to say that the time period that he was incarcerated and did not have the overall medication that his condition did not improve as a result of that?
A. Right. It didn't improve, right. And it may have worsened because he wasn't on blood pressure medication.



Q. And you could say that to a reasonable degree of medical certainty?
A. Well, yeah, because he didn't have medication. I don't know what his blood pressure was when he went into the prison. I don't think a blood pressure was taken when he went in. So it could have been the same blood pressure when he went in that it was in August of 2010 or '9, before he went to prison.
We know there was a period of time when he was on no medication, or appears to be on no medication. There is a period of time when he got to the prison where he's also on no medication.
And the first blood pressure that is taken, in the record that I see, he has hypertension that is appropriately treated.
Q. Okay. Based upon -- when you reviewed the autopsy report, was it -- was it a complete report or was it a summary?
A. Very superficial. It's just a summary. I've never seen the completed autopsy report. I don't know where that is.
Q. And the summary indicated that the cause of death is what?
A. Well, I think it is hypertensive heart

disease. If you have a copy of it I can look at it. I think he had hypertensive heart disease and he also had atherosclerosis.

The autopsy findings state, "Cardiomegaly with biventricular hypertrophy and severe atherosclerotic coronary artery disease. There are also some lung findings that I don't think are important, but emphysematous lung changes.

Q. What does all of that mean, Doctor? Take us through it a little bit at a time.

A. Well, he has an enlarged heart. The heart is very thickened in both sides; the right side and the left side. That's what biventricular means. And he has some disease of his coronary artery that's severe. And they read the cause of death as atherosclerotic coronary artery disease.

Q. So that's -- he had a heart disease?

A. Yeah. He had a heart disease, circulatory problems with his heart. Meaning he had an enlarged heart and a thickened heart.

Q. What is warfarin?

A. Warfarin is a blood thinner. He had a stroke back in 2008 and was placed on warfarin.

Q. What happens if you don't take the warfarin?



A. Well, your blood is not thin and you're at risk for stroke.

Q. What happens if you don't take the coreg?

A. Well, if you don't take the coreg, your heart problem won't get any better, especially if you're not taking it along with all the other medications that we prescribed, such as digitalis, digoxin, and lisinopril and then eventually Diovan.

So that is an important part of the cocktail. If you're saying -- if you could say that the treatment of heart failure is based on four corners of the chair, four legs of a chair and each leg being important, but does not in itself make the chair stand up. So you need all of those to help the heart get better. It is not a good analogy, but...

Q. And none of them would make it worse?

A. It will. If you get none, then we know the mortality is very high.

Q. Do you have to be deprived of the cocktail for a definite duration in order to do irreparable harm?

A. Well, the lack of adequate medication normally means lack of improvement, and places you at risk for further complication of your heart



condition, which includes death.

So he was at risk. Any time he was not taking the medication that the cardiologist prescribed to him, it was like going outside without an umbrella to protect himself, protect his heart.

Q. Would it be fair to say that you can't pinpoint any particular time where his condition is generated to a point of irrepair?

A. No. I could not do that. I would be speculating there.

Q. As far as you know, Doctor, if the regiment of medication had been reinstituted while he was incarcerated, he may very well have lived?

A. His best chance of survival was to be on appropriate medical therapy for his condition before he went to prison and even after he went to prison.

Q. And that's to a reasonable degree of medical certainty?

A. Yes.

Q. At what point, based upon your review of the medical records, did you determine that Mr. Graham needed an internal cardiac defibrillator?

A. Well, when you present and your ejection fraction is 10, 15 percent -- 15 percent, and this was back in 2007 when we probably weren't putting in



as many defibrillators as we are now, that would be a time when you would be alerted to the fact that this is a high-risk patient, high risk of dying when his cardiologist saw him back at South Central Regional Medical Center when he was short of breath.

You hope that with the appropriate treatment instituted by his cardiologist that there would be improvement of his heart function to greater than 35 percent from the 15 percent.

Unfortunately, he never went back to the cardiologist to receive those tests, which probably would have been done six months to a year later as a followup. He never got those tests done.

So we never knew what his ejection fraction was before he went to prison, while he was in prison, and after he died you can't get it, because it is how the heart is pumping.

So we expect with medication we expect them to hopefully get better. If they don't and the pumping function does not reach a certain level, then they might be a candidate for a defibrillator.

Q. Would it be fair to say that at the time that he was incarcerated that he was a candidate for a defibrillator?

A. I would be totally speculating on that.

I don't know what his number was. I expect that he could have been. If he was a candidate, because his heart function had not reached 35 percent, he would have to see a heart specialist and have an echo, and he never went back to see his heart specialist.

So the probability of seeing a heart specialist in prison is decreased because we don't have cardiologists on staff at the prison that I'm aware of.

Q. You don't know whether they have access to cardiologists?

A. Oh, they might have access, but not immediate access.

Q. I asked you that because you indicated in your statement that the failure to have a defibrillator contributed to his death.

A. No doubt about it. That was his best chance of survival. Even if he had been on medication, he still could have a cardiac arrest. The best chance of survival is to have an internal cardiac defibrillator.

Q. Okay. And the next best would be to take the medication?

A. Yeah. The next best is to take the medication, but medication may not get you to a



point where you don't need a defibrillator. And the best scenario would be a defibrillator.

Again, that requires a long-term followup with a specialist. That's not a determination made by a nurse or nurse partitioner or family medicine doctor. Only heart specialists who deal with it all the time would be the best people to make that decision.

MR. SANDERS: I don't think I have any further questions.

(Exhibit 2 marked.)

EXAMINATION BY MR. DARE:

Q. I am going to have marked as Exhibit 2 to your deposition the comprehensive cardiology report that you have been referring to.

Dr. Taylor, I am going to hand you what's been marked as Exhibit 2 to your deposition.

Can you identify that for me, please?

A. Yes. This is my report on Mr. Albert Graham that I submitted back in April of 2014.

Q. Is that a true and correct copy of the opinions that you will hold and that you do hold and that you would express at trial if asked to do so?

A. Yes.

Q. There has been some talk during your



deposition today about expectations for Mr. Graham.

In 2007, when Mr. Graham first presented with signs of congestive heart failure and had the 10- to 15 percent ejection fraction, assuming that he received best available treatment in 2007 and continued on, what would have been his average life span from that point?

MR. SANDERS: Object to the form.

THE WITNESS: Well, based on the ejection fraction of 15 percent, he has a high morbidity and mortality. And the five-year mortally untreated is probably 50 percent. I would say treated it would lower that to maybe about 20 percent. And then he also had some other social activities that could exacerbate his cardiac condition such as alcohol and cocaine. All those things could contribute or prevent improvement.

So life span, if he continued to use those drugs, along with a heart condition, you know, four, five years, maybe, probably less than that, to be honest with you.

Cocaine is a very bad drug for people with heart disease. It's a bad drug for people with good hearts, so it is definitely real bad for people with bad hearts. And then alcohol as a combination



with that, which his wife described, through the extent of his use would be a major detriment.

BY MR. DARE:

Q. Thank you, sir.

Would you like to read and sign your deposition, once that is through?

A. Yes.

MR. DARE: I tender the witness.

FURTHER EXAMINATION BY MR. SANDERS:

Q. In light of that testimony, would it be -- well, you said that the things that were mentioned could very easily shorten his life expectancy. Is that right?

A. Yes.

Q. Wouldn't that make it all the more important that he receive medical attention at the time that he was incarcerated?

A. Right. I think you ought to be treated for the medicine that you're on and for your problems that you have. If you have a heart problem, then you need your medication.

But also, the patient has a responsibility to also take his medication and also to let people know how and when he needs it.

Q. Okay. And when you say, "let him know,"

you're talking about what they recorded that he told you?

A. Right. Because he only mentioned one drug. In the record, now, he only mentioned coreg.

Q. Okay. Were you aware that this was not communicated to the nurse at the time he was incarcerated?

A. That information?

Q. Yes.

A. No.

Q. And you indicated you were not aware that she had gotten his medical records prior to sending him to the --

A. No. Because I haven't read her deposition. It wasn't in the medical record that -- I have not read her deposition. I have it, but I have not read it.

(Off the record 3:21 p.m.)



ERRATA SHEET

I, DR. MALCOLM TAYLOR, do solemnly swear that I have read the foregoing ____ pages and that the same is a true and correct transcript of the testimony given by me at the time and place hereinbefore set forth, with the following corrections:

Page: Line: Correction:

_____

_____

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_____

_____

_____

DR. MALCOLM TAYLOR

NOTARIZATION

I, _____, notary public for the State of Mississippi, _____ County, do hereby certify that Dr. Malcolm Taylor personally appeared before me this _____day of _____, 2014, at _____, Mississippi.

My Commission Expires:_____

_____

(NOTARY PUBLIC



CERTIFICATE OF COURT REPORTER

I, Tamika T. Bartee, Court Reporter and Notary Public, in and for the State of Mississippi, hereby certify that the foregoing contains a true and correct transcript as taken by me in the aforementioned matter at the time and place heretofore stated, as taken by stenotype and later reduced to typewritten form under my supervision by means of computer-aided transcription.

I further certify that under the authority vested in me by the State of Mississippi that the witness was placed under oath by me to truthfully answer all questions in the matter.

I further certify that I am not in the employ of or related to any counsel or party in this matter and have no interest, monetary or otherwise, in the final outcome of this matter.

Witness my signature and seal this the ____ day of _____, 2014.

_____

TAMIKA T. BARTEE, BCR, CSR#1782

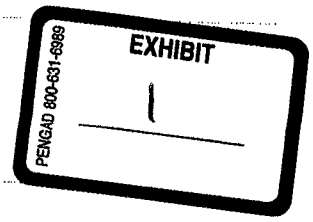
My Commission Expires:
June 10, 2016

Store #: 501
Report Date: 06/05/2014

**Connexus Pharmacy System**
**Wal-Mart Pharmacy10-501**
**Medical Expenses Summary**

**Patient:** GRAHAM,ALBERT,
2469 BUSH DAIRY RD
LAUREL MS-39443

**Birthdate:** 06/01/1951




Below is a list of your Pharmacy Orders for the date range of:01/01/2007 To 06/05/2014

**Wal-Mart Pharmacy,1621 HWY 15 NORTH, LAUREL MS-39440**
**NABP Number:2513984 ID: BW5376163 NPI Number :1609893007**

| Date Filled / Date Written | Rx / Fill ID | Drug Name / NDC | Prescriber / Physician NPI | Qty / Refill # | Days Supply | Dispense As Written | Patient Paid / TP Ref # |
|---|---|---|---|---|---|---|---|
| 11/27/2007 | 7714503 | CARVEDILOL 3.125MG TAB | PARKER,SCOTT R | 60 | 30 | 0 | $ 4.00 |
| 11/27/2007 | 3699629 | 00378-3631-01 | 1528155660 | 0 | | | |
| 11/27/2007 | 7714504 | LISINOPRIL 2.5MG TAB | PARKER,SCOTT R | 60 | 30 | 0 | $ 8.00 |
| 11/27/2007 | 3699631 | 00378-2072-01 | 1528155660 | 0 | | | |
| 12/11/2007 | 7718456 | CARVEDILOL 3.125MG TAB | NORTON,MARK | 60 | 30 | 0 | $ 4.00 |
| 12/11/2007 | 3709992 | 00378-3631-01 | 1881608495 | 0 | | | |
| 12/11/2007 | 7718460 | DIGITEK 0.125MG TAB | NORTON,MARK | 30 | 30 | 0 | $ 4.00 |
| 12/11/2007 | 3709995 | 62794-0145-01 | 1881608495 | 0 | | | |
| 12/11/2007 | 7718458 | DIOVAN 40MG TAB | NORTON,MARK | 30 | 30 | 0 | $ 57.62 |
| 12/11/2007 | 3709993 | 00078-0423-15 | 1881608495 | 0 | | | |
| 12/11/2007 | 7718455 | FUROSEMIDE 40MG TAB | NORTON,MARK | 60 | 30 | 0 | $ 8.00 |
| 12/11/2007 | 3709985 | 00378-0216-01 | 1881608495 | 0 | | | |
| 12/11/2007 | 7718462 | KLOR-CON M20 TAB | NORTON,MARK | 30 | 30 | 0 | $ 15.84 |
| 12/11/2007 | 3709996 | 00245-0058-11 | 1881608495 | 0 | | | |
| 01/31/2008 | 7718460 | DIGITEK 0.125MG TAB | NORTON,MARK | 30 | 30 | 0 | $ 4.00 |
| 12/11/2007 | 3746316 | 62794-0145-01 | 1881608495 | 1 | | | |
| 01/31/2008 | 7718458 | DIOVAN 40MG TAB | NORTON,MARK | 30 | 30 | 0 | $ 60.88 |
| 12/11/2007 | 3746315 | 00078-0423-15 | 1881608495 | 1 | | | |
| 01/31/2008 | 7718455 | FUROSEMIDE 40MG TAB | NORTON,MARK | 60 | 30 | 0 | $ 8.00 |
| 12/11/2007 | 3746317 | 00378-0216-01 | 1881608495 | 1 | | | |
| 02/08/2008 | 7734503 | WARFARIN 5MG TAB | MOUANNES,WASSIM E | 30 | 20 | 0 | $ 4.00 |
| 02/08/2008 | 3753656 | 62584-0994-77 | 1780799965 | 0 | | | |
| 02/18/2008 | 7714503 | CARVEDILOL 3.125MG TAB | PARKER,SCOTT R | 60 | 30 | 0 | $ 4.00 |
| 11/27/2007 | 3760777 | 00378-3631-01 | 1528155660 | 1 | | | |
| 02/18/2008 | 7718462 | KLOR-CON M20 TAB | NORTON,MARK | 30 | 30 | 0 | $ 15.84 |
| 12/11/2007 | 3760776 | 00245-0058-11 | 1881608495 | 1 | | | |
| 03/10/2008 | 7714503 | CARVEDILOL 3.125MG TAB | PARKER,SCOTT R | 60 | 30 | 0 | $ 4.00 |
| 11/27/2007 | 3778130 | 00378-3631-01 | 1528155660 | 2 | | | |
| 03/21/2008 | 7747278 | FUROSEMIDE 40MG TAB | MOUANNES,WASSIM E | 60 | 30 | 0 | $ 8.00 |
| 03/21/2008 | 3785909 | 00378-0216-01 | 1780799965 | 0 | | | |
| 03/28/2008 | 7734504 | DIGITEK 0.125MG TAB | MOUANNES,WASSIM E | 30 | 30 | 0 | $ 4.00 |
| 02/08/2008 | 3790858 | 51079-0945-63 | 1780799965 | 0 | | | |
| 04/04/2008 | 7714503 | CARVEDILOL 3.125MG TAB | PARKER,SCOTT R | 60 | 30 | 0 | $ 4.00 |
| 11/27/2007 | 3796073 | 00378-3631-01 | 1528155660 | 3 | | | |
| 04/11/2008 | 7718462 | KLOR-CON M20 TAB | NORTON,MARK | 30 | 30 | 0 | $ 15.84 |
| 12/11/2007 | 3800767 | 00245-0058-11 | 1881608495 | 2 | | | |
| 05/14/2008 | 7714503 | CARVEDILOL 3.125MG TAB | PARKER,SCOTT R | 60 | 30 | 0 | $ 4.00 |
| 11/27/2007 | 3823804 | 00378-3631-01 | 1528155660 | 4 | | | |
| 06/03/2008 | 7747278 | FUROSEMIDE 40MG TAB | MOUANNES,WASSIM E | 30 | 15 | 0 | $ 4.00 |
| 03/21/2008 | 3837178 | 00378-0216-01 | 1780799965 | 1 | | | |
| 06/24/2008 | 7714503 | CARVEDILOL 3.125MG TAB | PARKER,SCOTT R | 60 | 30 | 0 | $ 4.00 |
| 11/27/2007 | 3851983 | 00378-3631-01 | 1528155660 | 5 | | | |
| 07/31/2008 | 7747278 | FUROSEMIDE 40MG TAB | MOUANNES,WASSIM E | 30 | 15 | 0 | $ 4.00 |
| 03/21/2008 | 3877185 | 00378-0216-01 | 1780799965 | 2 | | | |
| 08/13/2008 | 7714503 | CARVEDILOL 3.125MG TAB | PARKER,SCOTT R | 60 | 30 | 0 | $ 4.00 |
| 11/27/2007 | 3887086 | 00378-3631-01 | 1528155660 | 6 | | | |
| 08/13/2008 | 7734504 | DIGOXIN 0.125MG TAB | MOUANNES,WASSIM E | 30 | 30 | 0 | $ 4.00 |
| 02/08/2008 | 3887088 | 00527-1324-01 | 1780799965 | 1 | | | |

Store #: 501
Report Date: 06/05/2014

**Connexus Pharmacy System**
**Wal-Mart Pharmacy10-501**
**Medical Expenses Summary**

Patient: GRAHAM,ALBERT,
2469 BUSH DAIRY RD
LAUREL MS-39443

**Birthdate:** 06/01/1951

Below is a list of your Pharmacy Orders for the date range of:01/01/2007 To 06/05/2014

**Wal-Mart Pharmacy,1621 HWY 15 NORTH, LAUREL MS-39440**
**NABP Number:2513984 ID: BW5376163 NPI Number :1609893007**

| Date Filled / Date Written | Rx / Fill ID | Drug Name / NDC | Prescriber / Physician NPI | Qty / Refill # | Days Supply | Dispense As Written | Patient Paid / TP Ref # |
|---|---|---|---|---|---|---|---|
| 08/13/2008 | 7747278 | FUROSEMIDE 40MG TAB | MOUANNES,WASSIM E | 30 | 15 | 0 | $ 4.00 |
| 03/21/2008 | 3887085 | 00378-0216-01 | 1780799965 | 3 | | | |
| 08/13/2008 | 7718462 | KLOR-CON M20 TAB | NORTON,MARK | 30 | 30 | 0 | $ 15.84 |
| 12/11/2007 | 3887087 | 00245-0058-11 | 1881608495 | 3 | | | |
| 10/24/2008 | 8825258 | ASPIRIN 81MG EC TAB | MOUANNES,WASSIM E | 30 | 30 | 0 | $ 4.00 |
| 02/08/2008 | 3939317 | 63739-0272-01 | 1780799965 | 0 | | | |
| 10/24/2008 | 7734505 | CARVEDILOL 3.125MG TAB | MOUANNES,WASSIM E | 60 | 30 | 0 | $ 4.00 |
| 02/08/2008 | 3939316 | 00378-3631-01 | 1780799965 | 0 | | | |
| 10/24/2008 | 7747278 | FUROSEMIDE 40MG TAB | MOUANNES,WASSIM E | 30 | 15 | 0 | $ 4.00 |
| 03/21/2008 | 3939314 | 00378-0216-01 | 1780799965 | 4 | | | |
| 01/12/2009 | 7734505 | CARVEDILOL 3.125MG TAB | MOUANNES,WASSIM E | 60 | 30 | 0 | $ 4.00 |
| 02/08/2008 | 3999649 | 00378-3631-01 | 1780799965 | 1 | | | |
| 01/12/2009 | 7734504 | DIGOXIN 0.125MG TAB | MOUANNES,WASSIM E | 30 | 30 | 0 | $ 4.00 |
| 02/08/2008 | 3999652 | 00527-1324-01 | 1780799965 | 2 | | | |
| 01/12/2009 | 7734506 | DIOVAN 40MG TAB | MOUANNES,WASSIM E | 30 | 30 | 0 | $ 62.36 |
| 02/08/2008 | 3999650 | 00078-0423-15 | 1780799965 | 0 | | | |
| 01/12/2009 | 7747278 | FUROSEMIDE 40MG TAB | MOUANNES,WASSIM E | 30 | 15 | 0 | $ 4.00 |
| 03/21/2008 | 3999651 | 00378-0216-01 | 1780799965 | 5 | | | |
| 01/12/2009 | 7734507 | KLOR-CON M20 TAB | MOUANNES,WASSIM E | 30 | 30 | 0 | $ 15.84 |
| 02/08/2008 | 3999654 | 00245-0058-11 | 1780799965 | 0 | | | |
| 01/12/2009 | 7734503 | WARFARIN 5MG TAB | MOUANNES,WASSIM E | 30 | 20 | 0 | $ 4.00 |
| 02/08/2008 | 3999655 | 62584-0994-77 | 1780799965 | 1 | | | |
| 06/05/2009 | 7852723 | CARVEDILOL 6.25MG TAB | MOUANNES,WASSIM E | 60 | 30 | 0 | $ 4.00 |
| 04/24/2009 | 4111228 | 00378-3632-01 | 1780799965 | 0 | | | |

Report Date :06/05/2014
Attested To By :

Registered Pharmacist

**Total:** $ 388.06

****PRIVATE-IF YOU RECEIVE THIS REPORT IN ERROR, PLEASE RETURN TO WAL*MART PHARMACY IMMEDIATELY.**
**WAL*MART STORES, INC.**

Malcolm P. Taylor, M.D., F.A.C.C.
971 Lakeland Drive, Suite 850
Jackson, Mississippi 39216
(601) 981-8543

Albert Graham

COMPREHENSIVE CARDIOLOGY REPORT

My name is Dr. Malcolm Taylor. I am a cardiologist in Jackson, Mississippi, and director of the Congestive Heart Failure Clinic at St. Dominic's Hospital. My qualifications and authored publications are attached in Exhibit A. I have reviewed the medical records of Mr. Albert Graham, including his multiple hospitalizations at South Central Regional Medical Center, clinic visits at the Hattiesburg Clinic, and the incident reports from the Jones County Detention Center. I have also reviewed the coroner's report, Walmart medication list, and records from Jefferson Medical Associates, the complaint, defense answers, and the depositions of Jeanetter Graham, Jerald Ulmer, and Terryl Ulmer.

Mr. Albert Graham was diagnosed with congestive heart failure in November 2007 when he presented to the South Central Regional Medical Center with shortness of breath. At that time, he was found to have a dilated heart with pulmonary congestion and a left ventricular ejection fraction of 15%. He was started on beta blockers, diuretics, and an ACE inhibitor. The etiology of this congestive heart failure was felt to be either viral or alcoholic. During that admission, he underwent a Myoview stress test which revealed significant left ventricular impairment with a fixed inferior and lateral wall defect and no evidence of myocardial ischemia. In February of 2008, he presented again to South Central Regional Medical Center with a complaint of right-sided weakness and was diagnosed with a stroke. The stroke was felt to be secondary to his dilated cardiomyopathy with ejection fraction of 10-15%. He also was noted to have nonsustained ventricular tachycardia and mild renal insufficiency. A transesophageal echo did not reveal any evidence of left atrial or left ventricular thrombus. A decision was made not to place him on Coumadin therapy because of a cavernous hemangioma noted on the CT scan during that admission. Patient was seen at the Hattiesburg Clinic periodically for treatment of his congestive heart failure by Dr. Wassim Mouannes, with his last visit to the Hattiesburg Clinic occurring on March 10, 2008. According to prescription records from Walmart pharmacy in Laurel, Mississippi, Mr. Graham last filled a prescription there for Coreg in June 2009.

On November 10, 2009, Mr. Graham was incarcerated at the Jones County Corrections Center because of aggravated assault. During that admission interview, he indicated that he was on medication, but listed Coreg as the only medication he was taking. In March 2010, Mr. Graham complained of possible elevation of blood pressure and feeling ill and was seen at the Ellisville Medical Clinic. The nurse practitioner who saw him at that time stated that he had not had any medications in over a year and started him on Lotensin/HCT 10/12.5 once a day for his blood pressure.

On April 6, 2010, Mr. Graham had a cardiac arrest while in his jail cell and despite CPR, could not be resuscitated. He was pronounced dead.

Mr. Graham had a severe dilated congestive cardiomyopathy with an ejection fraction of only 10-15%, which is associated with a high incidence of sudden death. His records indicate he had had abnormal cardiac arrhythmias during previous admissions to the hospital with congestive heart failure. There is no evidence that Mr. Graham's left ventricular ejection fraction improved from 2007 to his last admission in 2008.

Mr. Graham did not have a myocardial infarction but sudden death related to a cardiac arrhythmia which was, to a reasonable degree of medical certainty, caused by ventricular tachycardia and fibrillation. ("The American College of Cardiology / American Heart Association Task force on Sudden Death 2006.") Out of hospital cardiac arrest is associated with high mortality, with less than 50% survival rate, even with all appropriate treatment. The best treatment to prevent sudden cardiac death with nonischemic congestive cardiomyopathy is placement of an internal cardiac defibrillator, but there is no evidence in the record that this treatment was ever considered by his cardiologist in 2008.

Due to the fact that Mr. Graham suffered sudden death related to a cardiac arrhythmia, and due to the fact that Mr. Graham had not been on the appropriate medication for at least over a year, if not more, and did not have an internal cardiac defibrillator, then it is my opinion, to a reasonable degree of medical probability, that failure to provide Mr. Graham medication from November 2009 to March 2010 did not proximately cause or result in his death in April of 2010.

Each of my foregoing opinions are based upon my education, training and background as a cardiologist, and are stated to a reasonable degree of medical certainty.

Attached to this report are my qualifications and a list of any publications I have authored in the previous 10 years. I have also attached a list of other cases in which, during the previous 4 years, I have testified as an expert at trial or by deposition. A statement of compensation I charged for the study of records and my testimony in this case is also attached to this report.

Malcolm P. Taylor, M.D., F.A.C.C.

MPT/SW